



Mudgil Eye Associates, PC

Patient Registration (Please Print) [] NEW [] UPDATE

Name _____ Date _____
Last First Middle

Date of Birth ____/____/____ Soc Sec No. ____ - ____ - ____ Sex M F Marital Status: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Day Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Patient Employment Info:

Employer: _____ Phone _____ Occupation _____

Address _____

Street City State Zip

Responsible Party/Primary Insurance Subscriber: (If other than patient)

Name _____ Social Security No. ____ - ____ - ____ DOB ____/____/____

Address _____ Phone Number _____ Relationship _____

City _____ State _____ Zip _____

Primary Subscriber Employment Info:

Employer: _____ Phone _____ Occupation _____

Address _____

Street City State Zip

Insurance Information: (Please also present insurance card to front desk)

Subscriber _____ ID No. _____ Group No. _____

Insurance Company Name _____

Secondary Insurance (if applicable)

Subscriber _____ ID No. _____ Group No. _____

Insurance Company Name _____

Visit Information

Is this visit due to an injury? YES NO Is this visit Routine Problem

Workers Comp YES NO

Motor Vehicle Accident YES NO

Patient Signature

INSURANCE AUTHORIZATION FORM

MEDICARE AUTHORIZATION

“I request that payment of authorized Medicare benefits be made payable to me or on my behalf to Mudgil Eye Associates, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.”

“I am aware that REFRACTION, which is used to prescribe glasses, is not considered a part of medical care and is not covered by my insurance.”

Patient Name: _____ Medicare ID # _____

Provider Name: A. Vijay Mudgil, M.D. Date _____

I have read and agree with the above statement.

Patient Signature _____

**PROFESSIONAL SERVICES INSURANCE RELEASE
AND
ASSIGNMENT OF BENEFITS**

“I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me or my department by Mudgil Eye Associates, P.C.”

“I also authorize payment of benefits directly to Mudgil Eye Associates, P.C., such services as may be provided me or my dependent.”

“I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred by the above name patient, and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered.”

A photocopy of this authorization shall be considered valid.

Signature of Patient or Responsible Party _____ Date _____

NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) please sign here to acknowledge our compliance program /Notice of Privacy Practices * on display in the reception area.

Signature of Patient or Responsible Party _____ Date _____

*A printed copy of the Notice of Privacy Practices is available to you upon request.